FILED DEC 16 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

39252
STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1331

1. PLACE OF DEATH
a. COUNTY Buchanan
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Josephs Hospital — Length of stay in 1b 1 day

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Kansas b. COUNTY Doniphan
c. CITY OR TOWN Elwood 815 D — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 8 — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First Anson Middle M. Last Dotson
4. DATE OF DEATH: Month Day Year Nov. 27, 1957
5. SEX male
6. COLOR OR RACE white
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH July 12, 1902
9. AGE (In years last birthday) 55 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) proprietor
10b. KIND OF BUSINESS OR INDUSTRY Restaurant
11. BIRTHPLACE (City and state or country) Cherokee, Oklahoma
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Jess Dotson
13b. MOTHER'S MAIDEN NAME Eunice Frazer
14. NAME OF HUSBAND OR WIFE Eugenia Dotson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 512-10-7309
17. INFORMANT Address Mrs. A. M. Dotson, Elwood, Kansas

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Left Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH 4 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) arteriosclerosis — 1 yr.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331X
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 11.26.57 to 11.27.57 and last saw her him alive on 11.27.57
Death occurred at 9:00 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) R. H. Ryan M.D.
22b. ADDRESS St. Joseph, Missouri
22c. DATE SIGNED 11/29/57

23a. BURIAL, CREMATION, REMOVAL (Specify) burial
23b. DATE 11.29.57
23c. NAME OF CEMETERY OR CREMATORY Ashland, Cemetery
23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri

24. FUNERAL DIRECTOR Heaton-Bowman ADDRESS St. Joseph, Missouri
25. DATE RECD. BY LOCAL REG. Dec. 2, 1957
26. REGISTRAR'S SIGNATURE Mrs. Robert Fulton

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. ..... working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed William Goldberg

Licensed Embalmer No. 4535

P. O. Address 314 S. 10th, [illegible]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.